Health Reimbursement Account (HRA)
Mandatory Second Payer (MSP) Form

Mandatory reporting requirements apply to all HRA participants and their dependents as a result of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. These Mandatory Second Payer (MSP) rules ensure that Medicare does not pay for medical claims that should first be paid by another source and are designed to identify which entity is the primary payer. You are required to complete this form. If you do not have any dependents, only complete the "Your Information" section. If you are not eligible for, or currently participating in, a Medicare related program, **you must still report basic information for yourself and each of your dependents**. Dependents are the individual claimed on your Federal Tax Return (examples: spouse, children, etc.) Please complete a second form to report additional dependents. Call Capital Financial Group Inc at (518) 793-2885 or (888) 793-2999 with questions. **Please see sending instructions below.**

Your Information (Please print clearly)

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name: _____

Address: _____

_____

_____

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Are you eligible for Medicare? ☐ Yes ☐ No
If yes, complete the questions below:

Are you disabled? ☐ Yes ☐ No
If yes, provide Disable date:
___ ___ / ___ ___ / ___ ___ ___ ___

Are you in End-Stage Renal Disease? ☐ Yes ☐ No
If yes, provide End-Stage Date:

___ ___ / ___ ___ / ___ ___ ___ ___

Medicare Claim #: - - -

Your Dependent #1 (Please print clearly)

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name: _____

Address: _____

_____

_____

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Relationship to you: _____

Are you eligible for Medicare? ☐ Yes ☐ No
If yes, complete the questions below:

Are you disabled? ☐ Yes ☐ No
If yes, provide Disable date:
___ ___ / ___ ___ / ___ ___ ___ ___

Are you in End-Stage Renal Disease? ☐ Yes ☐ No
If yes, provide End-Stage Date:

___ ___ / ___ ___ / ___ ___ ___ ___

Medicare Claim #:___ ___ ___ - ___ ___ - ___ ___ ___ ___ - ___

By submitting this form, I certify that the information listed below is accurate to the best of my knowledge. I understand that this information is required to accurately coordinate benefits with Medicare and to meet mandatory reporting obligations.

Signed: _____ Date: _____

Employer Group: _____

Sending Instructions:
Mail to: Capital Financial Group, Inc.
89 Saratoga Avenue
South Glens Falls, NY 12803

Fax to: (518) 798-7502

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Instructions: Please provide information for yourself and all of your dependents. Dependents are the individuals claimed in your Federal Tax Return (examples: spouse, children, etc.) Please complete a second form to report additional dependents. Call Capital Financial Group, Inc. at (518) 793-2885 with questions.

Your Information: Name _____ **SSN:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Your Dependent #2 (Please print clearly)

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name: _____

Address: _____

_____

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Relationship to you: _____

Are you eligible for Medicare? ☐ Yes ☐ No
If yes, complete the questions below:

Are you disabled? ☐ Yes ☐ No
If yes, provide Disable date:
___ ___ / ___ ___ / ___ ___ ___ ___

Are you in End-Stage Renal Disease? ☐ Yes ☐ No
If yes, provide End-Stage Date:

___ ___ / ___ ___ / ___ ___ ___ ___

Medicare Claim #: - - -

Your Dependent #3 (Please print clearly)

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name: _____

Address: _____

_____

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Relationship to you: _____

Are you eligible for Medicare? ☐ Yes ☐ No
If yes, complete the questions below:

Are you disabled? ☐ Yes ☐ No
If yes, provide Disable date:
___ ___ / ___ ___ / ___ ___ ___ ___

Are you in End-Stage Renal Disease? ☐ Yes ☐ No
If yes, provide End-Stage Date:

___ ___ / ___ ___ / ___ ___ ___ ___

Medicare Claim #: - - -

Your Dependent #4 (Please print clearly)

SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Name: _____

Address: _____

_____

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Relationship to you: _____

Are you eligible for Medicare? ☐ Yes ☐ No
If yes, complete the questions below:

Are you disabled? ☐ Yes ☐ No
If yes, provide Disable date:
___ ___ / ___ ___ / ___ ___ ___ ___

Are you in End-Stage Renal Disease? ☐ Yes ☐ No
If yes, provide End-Stage Date:

___ ___ / ___ ___ / ___ ___ ___ ___

Medicare Claim #: - - -